What works? What fails?

FINDINGS FROM THE NAVRONGO COMMUNITY HEALTH AND FAMILY PLANNING PROJECT

Vol. 2, No. 16, April 2002 Navrongo Health Research Centre

WHO NEEDS RESEARCH?

What works?… spent a few minutes with Dr. John Gyapong, Director of the Health Research Unit of the Ministry of Health.

WW: You must be proud to have run an experiment whose results have been used for policy.

Dr. John Gyapong (JG): Certainly, that is a good thing. I think the findings make it clear that if you put trained health workers in a community to provide prompt health services to the people at their doorsteps, their health status would improve significantly.

WW: The Regional Directors of Health Services have produced a report on CHPS which indicates that there is something about CHPS that just does not tick.

JG: I have not seen the report but I assume they are probably looking at implementation issues. Under research conditions you want to establish that it works so resources, both human and material, are mobilized to ensure that the experiment is well done.

WW: What are the implementation issues?

JG: We are talking about health personnel at the community level as the primary thing. The question is, where are the health personnel to put in the community? We started in Navrongo using community health nurses. How many community nursing training schools are available? During the initial phase of the scaling-up process we did some calculations and realised that the rate at which our nursing training institutions train health staff it would take us over 20 years to train the required number of staff for CHPS.

Improving health through research is a lot to smile about

WW: This is a policy so you must have been looking for where to get the nurses. For instance, Navrongo is putting together a proposal to start a nursing training school.

JG: That is a step in the right direction. Policies only provide a framework for implementation. What is needed is to set guidelines or boundaries to determine what people are allowed to do and what they are not. The fact that the health sector appreciates the CHPS project does not necessarily mean that overnight every community is going to have a health worker placed there.

WW: Every community has a teacher so why shouldn't every community have a health worker?

JG: Yes, it makes sense, but look at the number of teacher training colleges and the numbers they produce. The attrition rate in the health sector is very high. Many of the nurses have left in search of greener pastures abroad. Apart from that we also have a situation where nurses are concentrated at facilities where they provide secondary or tertiary care. This is necessary though. Take Navrongo for instance, you can decide to put community health nurses or any category of staff in all the communities. But immediately somebody falls ill and it is beyond the community health nurse's ability they think of going to Navrongo hospital. And if you go to Navrongo hospital and there is no nurse, there would be chaos. So you must not just rush to start with the periphery, you also have to make sure that the secondary and tertiary care systems are in place to support the nurse. We have taken an inventory of what we require, the question is, where are the resources to come from?

WW: For CHPS to work, the community must own it. The community must understand it and look at it as their strategy to address their health problems.

JG: It is good to have community involvement, participation or however you term it. We must look at what the community must own. If you look at the concept of CHPS, the community must be responsible for providing certain basic things for a health worker put in a community. The Navrongo experience has shown that the community members can provide accommodation and other necessities to make the health worker feel at home. But the community involvement does not solve the problem. Somebody must supervise the health workers there. Somebody

must make sure that drugs are available and the right things are done. And this is a health systems issue. The community must own it, I agree but at the end of the day ownership from the technical perspective must come from the health sector.

WW: Can communities implement CHPS without support from development partners?

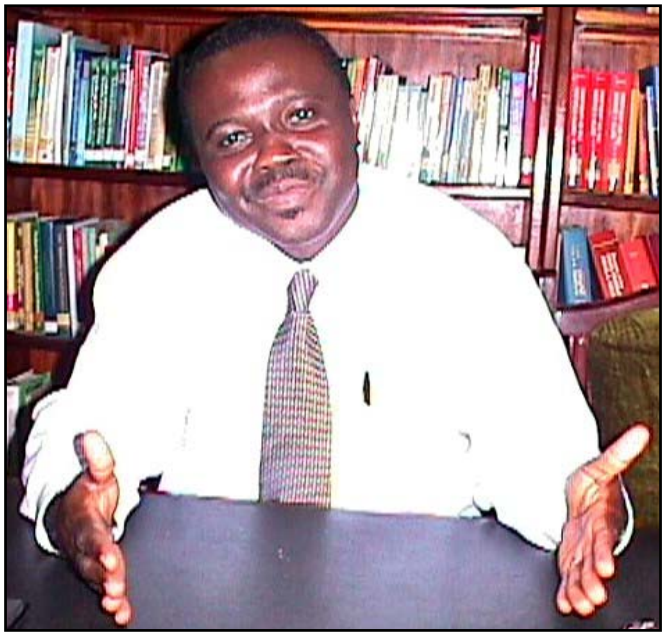
JG: The first point is how much it is going to cost us to implement this strategy? As far as I know, that planning exercise to determine this has not been done. There is the Government of Ghana (GOG) fund which is what the finance ministry allocates the health sector. Then we have the Internally Generated Fund (IGF) but these are insufficient—so whether we like it or not the health sector needs assistance from development partners.

WW: Under the Navrongo experiment there was the health committee, health volunteers, the CHC and the CHO. Would you say these are the core components of any community-based health care delivery?

JG: I think we should look at the data that is available. There is some debate as to whether the role of the village volunteer, is not even detrimental in terms of adverse mortality in those communities. You know that sometimes when you empower the volunteers, out of zeal they go beyond their limits. I need to see that kind of data. But having said that, I think it would be very useful it the health worker has a partner in the community to work with. That would make things a lot easier.

WW: From CHFP to CHPS, how does Navrongo fit in?

JG: I personally think that Navrongo has a role to play in terms of providing technical expertise. But we must be careful Navrongo does not begin to launch CHPS. Otherwise, we cannot concentrate on the research that we are supposed to be doing to inform policy formulation. But there is also the aspect of policy implementation. When policy is being implemented, operational research is carried out to inform the process, but I don't believe Navrongo should be taking the lead in the implementation of CHPS because its mandate is research, not implementation. So my point is that if there are some research issues that come up in the course of the implementation of CHPS, then technically Navrongo comes in. Navrongo can also provide technical support to districts implementing CHPS. Technical support pre-supposes that there is a group who knows it all. And if there is a group who knows it all, it must be Navrongo. I see Cooperating Agencies have become technical advisors on the CHPS project. That is unacceptable. We cannot develop a system ourselves and someone else comes to tell us how it works!



A lot in his hands to back health policy

WW: Who should say Navrongo is best placed to provide technical support to CHPS?

JG: If there is a group of people in Navrongo who have the expertise in supporting the running of programmes, or even people who are in the position to provide the technical support that we are taking of, I think that we would have to look at it carefully. I haven't tried that before but I think that is something that can be experimented. We could look at the possibility of having some core group of people who are in the position to advise on vital issues regarding CHPS. This would not necessarily be a full-time job. It should be a standing team of people who have run the Navrongo experiment from the beginning and know enough what it entails to be able to offer advice on authority.

Send questions or comments to: What works? What fails?
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This series has been launched to share experiences with people in Ghana and elsewhere around the world about what has worked and what has failed in an experiment to make primary health care widely accessible to rural people. The Kassena-Nankana community, whose active participation made *The Navrongo Experiment* possible, are hereby duly acknowledged. This publication was made possible through support provided by the Office of Population, Bureau for Global Programs, Field Support & Research, U.S. Agency for International Development, under the terms of Award No. HRN-A-00-99-00010. The opinions expressed herein are those of the authors and do not necessarily reflect the views of the U.S. Agency for International Development. Additional support was provided by a grant to the Population Council from the Bill and Melinda Gates Foundation.